PacificSource
HEALTH PLANS

February 25, 2026

Senator Deb Patterson, Chair
Senator Cedric Hayden, Vice-Chair
Oregon Legislative Assembly
Senate Committee on Health Care
900 Court St. NE
Salem, OR 97309

Delivered via OLIS.

Re: Opposition to House Bill 4028A; Relating to Behavioral Health Audits (2026)

Chair Patterson, Vice-Chairs Hayden, and members of the committee:

The PacificSource companies are independent, not-for-profit health insurance providers based in Oregon. We serve over 500,000 commercial, Medicaid, and Medicare Advantage members in three states. PacificSource Community Solutions is the contracted coordinated care organization (CCO) in Central Oregon, the Columbia River Gorge, and Marion & Polk Counties. Our mission is to provide better health, better care, and better value to the people and communities we serve.

We write in opposition to House Bill 4028A, a bill that we have opposed in 2023 as House Bill 2455 and in 2025 as House Bill 2029. As we have stated repeatedly, we too want to ensure a balance between our provider partners' administrative burden and our responsibilities to the state and federal government (not to mention our members) to limit fraud, waste, and abuse. However, we believe that House Bill 4028A moves the pendulum too far away from ensuring program integrity and accountability.

How PacificSource Conducts Audits

First, though, we wish to address how the process works at PacificSource. Our compliance and program integrity plan that apply to commercial health benefit plans look to Medicare standards:

- After receiving a complaint or through a random sampling, we request medical records for members, or for a date range.
- We make available an electronic portal for ease of submitting information. Providers have 30 calendar days to supply records.
- If the records received from the provider support the claims made, no further action is necessary. If records do not support the claims audited, then we may need to take further action (e.g., denying similar future claims, provider education, recoupment).

We ensure to make freely available to our provider partners a comprehensive manual that outlines, among other things, procedures on program integrity.[1] Our manual outlines examples of fraud, waste, and abuse as well as outlines the process of undertaking program integrity audits with providers. We feel that a separate document setting out these standards (of which failing to disclose bars us from engaging in reasonable auditing standards) is at best unnecessary.

Preemption of HB 4028A by Medicaid Regulations

To our concerns with the bill, we think federal law will likely preempt application of the bill to the Oregon Health Plan. Medicaid payment integrity rules[2] and corresponding CCO contract requirements[3] require coordinated care organizations to implement and maintain procedures designed to detect and prevent fraud, waste, and abuse. These rules require managed care organizations (like Oregon's CCOs) to adopt provisions for prompt reporting of all overpayments identified and recovered, especially those that specify overpayment due to fraud.

Federal regulations specifically require that CCOs verify, through sampling or other methods, whether services were received by our members on a regular basis.[4] The Oregon Health Authority (OHA) Program Integrity Unit also performs audits on providers, which are generally conducted in synchronization with coordinated care organization audits. OHA regulations also require random sampling of claims to detect and deter fraud, waste, and abuse.[5] Sampling only when there is a high probability of an error, as HB 4028 provides, undermines the point of random sampling.

Interaction with Oregon's Insurance Code

Second, we note that Oregon's Insurance Code already places conditions on how commercial health benefit plans may recoup claims paid to providers.[6] The limited conditions under which commercial health benefit plans may recoup claims have an exception for fraud, waste, and abuse. House Bill 4028 would likely conflict with and limit existing law applicable to commercial insurers. Since this bill does not repeal the existing standards, we will have two different standards for behavioral health providers and for physical health providers. This will be administratively burdensome for providers who provide care in both settings. Complexity adds, time, cost, and abrasion that no one wishes to experience in the claims process.

This bill, like legislation introduced before it, prohibits health plans from recouping reimbursement in the case of "clerical errors," which are defined in the base bill as "minor error[s] in the keeping, recording or transcribing of records or documents or in the handling of electronics or hard copies of correspondence." Clerical errors may be isolated instances or could occur in a pattern of conduct that could point to potential fraud, waste and abuse in the claims process. Simply characterizing all clerical errors as harmless and exempt further limits health plans' abilities to deter fraud.

Thus, limiting the ability for health plans to deter and detect fraud, waste, and abuse inconsistent with federal standards creates risks for health plans and may lead to higher premiums paid by individuals and small businesses.

Our recommendation, if the committee does decide to move forward with the bill, is to align standards across lines of insurance (commercial and Medicaid) with Medicare program integrity rules for addressing fraud, waste, and abuse.

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[1] https://pacificsource.com/sites/default/files/2023-03/PRV1_0323_ProviderManual.pdf
[2] *See* 42 CFR § 438.608.
[3] 2023 contract template available at https://www.oregon.gov/oha/HSD/OHP/CCO/2023-CCO-Contract-Template.pdf
[4] 42 CFR § 438.608(a)(5).
[5] OAR 407-120-1505(8).
[6] ORS 743B.451

New Reporting Requirements Make Oregon an Outlier

The 2026 legislation before this committee adds new reporting requirements to a statute, ORS 743B.427, which seeks to incorporate federal mental health reporting requirements into Oregon's Insurance Code. This current bill only applies reporting requirements to fully insured health plans, which extend to about 23% of Oregonians in the state. Plans covered by the Employment Retirement Income Security Act of 1974, as amended, as well as Medicaid and Medicare do not have to report on this data. We fail to understand what the new reporting requirements purport to achieve, as is evident from the draft commercial plans already report voluminous data to the Department of Consumer and Business Services.

Other Technical Problems with the A-Engrossed Draft

- In section 2(1)(e) of the bill, the definition of fraud appears to be created out of whole cloth. Normally, in a civil context actions for fraud only run for two years.[7] This definition, not tied to anything, may not have a statutory limit.

- Section 2(2) and section 4(2) of the bill requires health plans and CCOs make available to "all" providers a description of how to submit a claim that will not be audited in the future. But the bill purports to only cover behavioral health providers. Does the term "all providers" mean everyone contracted with a health plan, even those providers not subject to the bill?

  Even if the intent was to cover only those providers who offer behavioral health treatment, then health plans and CCOs will be asked to write one extremely detailed manual for a small subset of providers and retain the more general manual for everyone else. We will have to write with excruciating detail, because if we do not cover all permutations of how to not be audited we may not recoup, even if the conduct could fall under the new definition of "fraud."

- In section 2(2)(c) and section 4(3)(c), audits must be conducted by a behavioral health professional. This may make sense in the context of determining if a course of treatment is working for a member and should be continued, but audits are a function of compliance with contractual provisions and financial requirements. These provisions fail to recognize that auditors are a specialty themselves, and finding an auditor with combined credentials will be quite difficult.

- Section 4(6) of the bill place limitations on how CCOs may recoup payments identified in an audit as requiring recoupment. CCOs must offer to work with a provider on a repayment plan. However, under Medicaid regulations, managed care organizations like CCOs must recoup provider overpayments within 60 days of when the MCO identifies that an overpayment occurred.[8] To comply with this section, CCOs could only offer repayment terms of 60 days or less to avoid False Claims Act liability. In contrast, under section 2(9)(b), health plans must offer repayment terms of three years for amounts for which the provider was not entitled.

- In section 2(10), an insurer may not conduct "a new audit of any claim" while another audit is in process. For entities like PacificSource who act as both health plan and CCO, if there have reason to believe that a provider may need audited (or are randomly audited) the audit scope may need to include all lines of business if the provider is contracted to be a commercial and Medicaid provider. This could add complexity and administrative burden on both the provider and on the payer.

[7] *See* ORS 12.110.
[8] 42 CFR § 438.608.

For these reasons, we respectfully oppose this legislation. We would, as we have in sessions past, like to instead work with the proponents before a bill is introduced to determine how to limit where practicable the impact of auditing requirements on small businesses, while limiting the impact on smaller, not-for-profit health plans like PacificSource.

Thank you for your consideration. Please do not hesitate to contact me at richard.blackwell@pacificsource.com with questions or concerns.

Sincerely,

/s

Richard Blackwell
Director, Oregon Government Relations